

Projects supporting mental health have been part of the BAB programme since the beginning, in recognition of the significant role this can play in reducing loneliness and isolation.

We began with 5 wellbeing pilot projects (November 2016 – August 2017) and then used the learning from these pilots to inform our commissioning of 3 larger wellbeing services:

- 1) Talking Therapies, delivered by Second Step.
- 2) Talking Therapies, delivered by Oasis Talk and Carers Support Centre.
- 3) BAME Wellbeing, delivered by Oasis Talk.

This Learning Digest **shares our key learning and recommendations about mental health and wellbeing**, drawn from these three specific mental health services but also wider learning from our other projects that work in the community.



Location

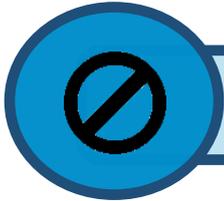
Travelling to where the therapist is based may not be suitable for many people including:

- Those with **low mobility and physical health conditions**. Older people are more likely to have mobility difficulties due to disabilities and long-term health conditions.
- Those who are **carers**, as they may not be able to leave the person they are caring for.
- Those in **socio-economically disadvantaged areas**, who may experience a number of barriers including transport costs and perceptions of certain neighbourhoods as unwelcoming.
- Communities where there are **high levels of stigma** around mental health (see learning point 2 below).

Our recommendation:

To overcome this barrier of location, mental health services need a **mixed model which can offer people a choice of how and where they access support**, including face-to-face, telephone, home-based or in a community venue. Home visits are particularly vital and can reach a client group who would not usually access other services.

By delivering a mixed model, it enables some **clients to progress through locations**. For example an individual who may require a home visit at first due to anxiety levels may later be able to attend appointments at an external location as their mental health improves.



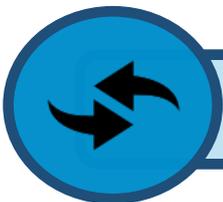
Cultural stigma

Many groups and communities have **high levels of stigma around mental health**, including amongst older people and BAME communities of all ages. In the context of this stigma, an individual is less likely to recognise that they need wellbeing support and then single themselves out by accessing it. This is reflected in the **low number of referrals** made to IAPT services in 2018 for BAME individuals (12%) and for people aged 65+ of any ethnicity (7%)¹.

Our recommendation:

In the context of stigma it works well to **provide lower-level wellbeing support in a group setting, outside of a clinical environment**. The stigma around mental health is different in each community, with different understandings and concerns. Support therefore needs to be **tailored to the community**, with the involvement community members themselves.

This lower-level wellbeing support should **occur in places where that specific community already meets**, for example community centres or faith venues. By providing this initial support, people still receive wellbeing information and realise they are not alone in their experiences without having to single themselves out or directly ask for help.



Adapting to service users

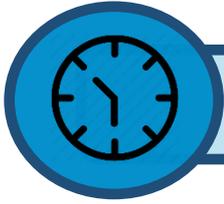
Services work best when they are **informed by service users** through their **involvement in service design and delivery**. BAB wellbeing services found this particularly important regarding DNA ('Did Not Attend') policies; strict policies were unsuitable for older people with long-term health conditions who had multiple medical appointments to fit around and in some cases were admitted to hospital.

Our recommendation:

Service models should include **formal and informal mechanisms for service user input and co-design** at all stages of the service. This might include steering groups, service user boards, feedback forms, opportunities to informally suggest ideas or clients becoming volunteers.

However, for these processes to bring genuine value, models need to be open to adaptation and staff need to be willing to listen and reflect. In some cases this may involve significant adaptations to the original model.

¹ Baker, C. (2018). Mental Health Statistics for England: Prevalence, Services and Funding. House of Commons Briefing Paper.



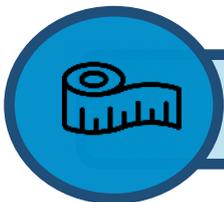
Length and number of sessions

Talking Therapies commonly offer up to 6 sessions of therapy, each lasting 50 – 60 minutes. This may be unsuitable for some people due to:

- The **nature of chronic loneliness**; the therapist may be the only person that individual sees each week. A longer session may be needed to allow time for the individual to talk, express themselves and process things at a slower pace without feeling rushed.
- For older people, it may be the **first time in their lives that they have accessed mental health support**. It takes time for them to build up trust with the practitioner and they may have complex lifelong issues to work through, possibly requiring longer sessions or a greater number overall.
- When therapy is via the telephone, it can be more tiring than face-to-face support due to the **lack of visual cues**. Shorter sessions may therefore be needed in these circumstances.

Our recommendation:

Flexibility needs to be built into service models, allowing the length and number of sessions to be tailored to the individual circumstances. In order to have this flexibility, models need to have an **agreed framework for deciding when to extend the number of sessions beyond 6**. This decision should be made jointly by the therapist and a clinically-informed line manager in order to balance the wish to tailor to the individual, while also meeting the needs of those on the waiting list.



Specialised services for older people

Mental health services often have a **lower uptake among older people**². This may be due to a number of reasons, for example stigma around mental health within this age group, or changes to how NHS services are accessed compared to previous decades.

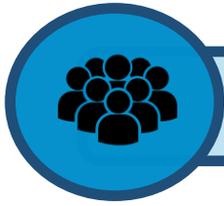
Some clients within the BAB wellbeing services reported **previous negative experiences with mental health support**, including therapists assuming that they feel lonely or depressed *because* of their age, and that this is simply a natural part of ageing. This can result in lower therapeutic expectations for older clients compared to younger clients.

Our recommendation:

Specific mental health **support tailored to people aged 50+**. This would enable these therapists to be skilled in the circumstances that disproportionately affect this age group such as long-term health conditions or bereavement.

Moreover, a **direct connection between physical therapists and mental health therapists** would enable both services to work in tandem regarding an individual, providing support that complements each other and boosts effectiveness. This would require the alignment of physical and mental health services, both strategically and operationally.

² Baker, C. (2018). Mental Health Statistics for England: Prevalence, Services and Funding. House of Commons Briefing Paper.



Support within a community setting

In addition to specialised mental health services, it is also important for people to have access to **lower-level wellbeing support in their local community**, for example peer-support groups or local social/activity groups.

This can function as **preventative support before** specialised mental health services are needed, and as a way to **maintain wellbeing** for those who have already accessed formal support.

One example of this within BAB is a **bereavement peer-support group** set up in Stockwood with the support of a community development worker from St Monica Trust (funded by BAB from September 2017 – December 2019). This form of wellbeing support is valuable for a number of reasons including:

- People can access it immediately without having to wait for a vacancy.
- It is free for individuals to access, thereby overcoming any potential financial barriers.
- It is in the local area, in a comfortable and safe environment that many individuals will be familiar with.
- There are no assessments or criteria that need to be met.
- Individuals can attend for any length of time, without being restricted by a maximum or minimum. This recognises the highly individual nature of mental wellbeing.

Our recommendation:

There need to be enough **community activities available in each local area** that are adequately resourced and supported by high-quality community development workers. This should include support to **develop community groups that provide peer-support**. In this way, mental health services are most effective when there is joined-up working with **community development work, and with social prescribing services** who can connect individuals to these groups.



Sustainability

In order to **maximise the impact** of mental health support, **sustainability** needs to be built into the service models. This will vary depending on the service but may include:

- Ensuring that lower-level peer support groups in the community have a sustainable model and can respond according to local needs.
- Training community members to be the volunteer facilitators of different wellbeing topics.
- Supporting volunteer health & wellbeing champions within different communities who are knowledgeable about the mental health support available and how to access it.

Our recommendation:

Expand traditional mental health service models to **include a focus on sustainability**. The starting point for this may be to ensure that current and former clients are involved in the design and delivery of the service, getting their input about **what would have helped them to maintain their wellbeing** after the formal support finished. Sustainability may also involve **connecting with existing community groups** in the places where individuals go on a day-to-day basis.